Indiana State Department of Health

LTC Newsletter

LTC & ICF/MR HOMES

Volume 5, Issue 3 *Division of Long Term Care Publication* *October 2005*

Department of Health Staff Assist With Hurricane Katrina Relief

Cathy Emswiller and Donna Groan pose with Governor Mitch Daniels at the beginning of their deployment to Mississippi.

Cathy Emswiller, Donna Groan, David Miller and Randall Fry, Division of Long Term Care (Division) Public Health Nurse Surveyors, each spent two unforgettable weeks lending a helping hand to Hurricane Katrina victims along the Mississippi Gulf Coast. They joined with other health care professionals from across the state during their respective deployments to assist with Operation Hoosier Relief, a team of volunteers assembled through the efforts of the Indiana Department of Homeland Security.

Cathy Emswiller, who serves as a quality review staff member with the Division, worked in several different locations during her deployment, including makeshift clinics outside a Red Cross Shelter and in a church parking lot. While assisting in a mobile clinic set up in the parking of a Baptist church, Emswiller spent four days providing direct patient care to what seemed to be an endless sea of people. "I'd say in that four days we saw probably over 1500 people," Emswiller said. While at this clinic, she even assisted a physician in performing a couple of minor surgeries. Emswiller also assisted the Mississippi State Department of Health in contacting nursing homes, hospitals, clinics and other medical facilities in a six-county area to conduct a needs assessment of medicines and supplies. The long list of needed items were communicated to the International Aid Society, who promptly delivered them to a central location within 24 hours to be pick up by health care professionals.

Donna Groan, who serves the Division as a surveyor in Area 5 (southwest portion of Indiana), primarily worked in a makeshift clinic inside Our Lady of Fatima Catholic Parish in Biloxi, Mississippi. Groan assisted with conducting nursing assessments and gave immunizations. One woman impacted her greatly. "I'll never forget looking into her eyes… there was nothing there. Just sorrow and loss." Groan also remembers one 14-year old teen named Jesus, whose father would drop him off each morning to assist with the relief efforts. One day, Groan said that Jesus complained of feeling sick. She had noticed that he was exhibiting signs of dehydration. Groan and a nurse practitioner saw that this tireless teen took regular breaks and drank plenty of Gatorade. "It was like leaving family when we left. I'm still in contact with some of those people from down there," Groan said.

For Emswiller, the thing that most impacted her did not necessarily involve the provision of health care. "Two days before we left, we worked outreach, going yard to yard, for there were seldom any doors left on the homes. We saw a mother and her little boy searching through the rubble of what used to be their home. We watched as the boy found his kitten, still alive well over two weeks after the hurricane had hit. You would have thought someone had given him a million dollars."

Inside This Issue

Inserts This Issue

IMMEDIATE JEOPARDIES

The Division of Long Term Care identified 47 situations of immediate jeopardy (IJ) in long-term care and ICF-MR facilities so far this calendar year, five of which were not removed prior to survey exit.

The concerns varied widely:

- Failure to provide adequate supervision to prevent resident to resident verbal, physical and/or sexual abuse
- Failure to provide adequate supervision and implement systems to prevent elopements
- Failure to provide adequate supervision and interventions to prevent recurrent falls with injury or potential for injury
- Failure to assess residents who smoke for safety issues
- Failure to ensure residents were correctly identified prior to administering medications
- Failure to ensure residents received physician ordered testing related to medications that require such testing to ensure that therapeutic levels are maintained
- Failure to provide CPR to full code status residents
- Failure to develop and implement policies for the prevention, reporting and investigation of allegations of staff to resident abuse, mistreatment and neglect, and for the protection of residents during such investigations
- Failure to ensure a resident was free from involuntary restraint and seclusion
- Failure to ensure proper utilization of restraints
- Failure to provide safety from environmental hazards and unsafe environmental conditions

The number of IJs has increased somewhat over the past three years, although not significantly. In 2002, 37 situations of IJ were identified. In 2003, the number rose to 40. In 2004, the number inched up to 41.

If the IJ situation is unremoved (the immediacy of the danger to residents) at the time of survey exit, discretionary denial of payment for new admissions is recommended for imposition with only a two-day notice, and the facility faces termination on the 23rd day after survey exit. Typically, state sanctions are imposed immediately, to include a ban on new admissions, placement of a monitor at the facility's expense. If the IJ situation is removed prior to survey exit, denial of payment for new admissions may be imposed within two days if the facility exhibits a history of multiple occurrences of harm level noncompliance in the past two survey cycles; otherwise, the denial of payment would normally be imposed to be effective 90 days after the survey exit.

Top 10 LTC Tags Cited July through September 2005

1. F324 Accidents
2. F281 Comprehensive Care Plans
3. F309 Quality of Care
4. F157 Notification of Changes
5. F314 Pressure Sores
6. F514 Administration
7. F371 Sanitary Conditions-Food Prep & Service
8. F253 Housekeeping/ Maintenance
9. F323 Accidents
10. F279 Comprehensive Care Plans -tied with- F315 Urinary Incontinence

CONSULTANTS WANTED

The Division of Long Term Care at the Indiana State Department of Health (ISDH), administrator of the Civil Money Penalty Fund Consultant Program, is seeking qualified individuals for inclusion in the program.

The program places consultants in participating long-term care facilities at no cost. The program is designed to assist facilities in achieving Medicare/ Medicaid compliance. Consultants, in conjunction with the facility staff, are responsible for developing a work plan to address facility specific issues and to provide professional consultation services to assist in implementation of the work plan. The Civil Money Penalty Fund pays the consulting fees.

The ISDH is currently seeking professionals in the following long-term care professional areas: Health Facility Administrators, Nurse Consultants, Registered Dieticians, Social Services, and Activities personnel. Qualified participants must attend a one-day mandatory training session and enter into a contract with the ISDH prior to placement in a participating facility.

Consultants may not be currently employed in their professional capacity by a long-term care facility. In addition, placement cannot be made within a facility in which the consultant has either been employed by or provided consultation to within the previous twenty-four months.

To obtain an application packet, contact, Randy Snyder, Director, Policy and Program Development at 317.233.7948 or by email to rsnyder@isdh.in.gov . The deadline for completed applications is October 31, 2005.

Top 10 ICF-MR Tags Cited July through September 2005

1. W149 Staff Treatment of Clients
2. W104 Governing Body
3. W249 Program Implementation
4. W154 Staff Treatment of Clients
5. W263 Program Monitoring & Change
6. W227 Individual Program Plan
7. W120 Services Provided With Outside Resources
8. W460 Food and Nutrition Services
9. W210 Individual Program Plan Incontinence
10. W440 Evacuation Drills

Plans of Correction and Revisits

Recently there has been some confusion involving where to send Plans of Correction (POCs) depending on the number of revisits in a survey cycle. This article seeks to clarify the requirements at each step in the cycle.

The POC for each survey, each Post-Certification Revisit (PCR) or first revisit, each second PCR or revisit, and each third PCR or revisit must be sent to the Indiana State Department of Health, Division of Long Term Care (Division) only. After a second revisit in a survey cycle that finds that the facility has not achieved substantial compliance, the Division must approve the POC and then request permission to conduct the third revisit from the Centers for Medicare and Medicaid Services (CM") Chicago Region V Office.

The POC prepared in response to the *third revisit* survey report that has federal deficiencies at scope and severity levels D through L must be sent to the Division *and* to CMS to the attention of:

Heather A. Lang
Principal Program Representative
Centers for Medicare & Medicaid Services
Division of Survey and Certification
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Chicago, IL 60601
Phone (312) 886-5208
Fax (312) 353-8053
heather.lang@cms.hhs.gov

In addition, the facility will be contacted by Sue Hornstein, Director, Division of Long Term Care, to set up a meeting at the Indiana State Department of Health for the facility, the survey area supervisor, and Ms. Hornstein to discuss the facts that the Division may use to justify a request for a fourth revisit. The Division must submit a request for a fourth revisit to CMS Region V, which then must seek permission from the CMS Central Office in Baltimore, Maryland.

All third revisits in a cycle must be conducted onsite regardless of the level or area of noncompliance, except for substantial compliance. The Division may no longer complete paper compliance for a third revisit.

For more information on this subject, you may contact Kim Rhoades, Survey Manager for the Division, at 317/233-7497, or at krhoades@isdh.in.gov.

What You Need to Know About Medicare Part D

✔ On January 1, 2006, new prescription drug coverage will be available to your Medicare residents. It will cover brand name and generic drugs.

✔ Starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare.

✔ All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid must enroll in a Medicare Prescription Drug Plan to get continuous coverage of their prescription drug costs.

✔ If Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid do not enroll in a Medicare Prescription Drug Plan by December 31, 2005, Medicare will enroll them in a plan automatically to make sure they do not miss a day of coverage.

✔ Medicaid beneficiaries who live in a nursing home will pay nothing out of their pocket for Medicare prescription drug coverage.

✔ If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to http://www.medicare.gov for additional information and assistance.

For more information and resources regarding the implementation of Medicare Part D prescription drug coverage, check out Medicare's Toolkit for Health Care Professionals at

http://www.cms.hhs.gov/medlearn/drugcoverage.asp#bene

PANDEMIC INFLUENZA PLAN

The Indiana State Department of Health has completed a Pandemic Influenza Plan designed to help the state prepare for and respond to a possible widespread and deadly influenza outbreak. An influenza pandemic is a global outbreak of disease that occurs when a new influenza virus appears or "emerges" in the human population, causes serious illness, and then spreads easily from person to person worldwide. New viruses are beginning to appear in Asia and Indonesia.

A pandemic outbreak will affect all health care providers. Unlike seasonal influenza, there will not be a vaccine available until well into the active pandemic phase. Therefore, Long-term care facilities are encouraged to participate in pandemic planning by:

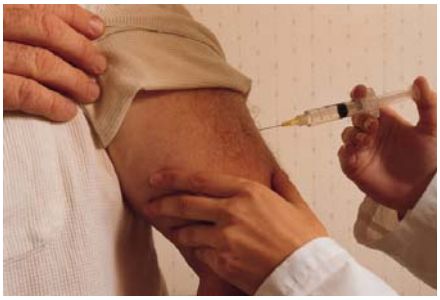
- Contacting the local hospital. Hospitals generally have transfer plans in place that involve transferring patients to long-term care sites during a surge event. In addition, they have begun planning for a pandemic as part of the federal bioterrorism grant program.
- Contacting the local health department for information regarding plans at the local and district levels.
- Developing plans for preventing and controlling the spread of a pandemic virus among staff and residents beyond routine daily infection control practices.
- Developing staffing plans to account for a high absentee rate during a pandemic outbreak.
- Maintaining vigilant "respiratory hygiene" practices such as covering your mouth when you sneeze or cough and washing your hands.
- Keeping current with new information as it becomes available.

For a copy of the Pandemic Influenza Plan go to: http://www.in.gov/isdh/pdfs/PandemicInfluenzaPlan.pdf
A list of frequently asked questions may be found at: http://www.in.gov/isdh/pdfs/PandemicInfluenzaQandA.pdf or for additional information, contact Janet Archer, Indiana State Department of Health at 317-234-3915.

CMS WILL REQUIRE NURSING HOMES TO VACCINATE RESIDENTS AGAINST THE FLU

Nursing homes serving Medicare and Medicaid patients will have to provide immunizations against influenza and pneumococcal disease to all residents if they want to continue in the programs, according to a final rule published by CMS in today's *Federal Register.*

As a condition of participation in the two programs, nursing homes will be required to ensure that residents received the immunizations. The resident or the resident's family can refuse the shots. Residents who cannot receive the vaccines for medical reasons are exempt. Under the final rule, nursing homes will also be required to educate the resident and/or the resident's family about the advantages and possible disadvantages of receiving the vaccines.



About two million Americans, most age 65 years or older, live in long-term care facilities. People aged 65 years and older account for more than 90 percent of influenza-related deaths in the United States and elderly nursing home residents are particularly vulnerable to influenza-related complications. In addition, the elderly are more likely than younger individuals to die from pneumonia.

In light of these statistics and in line with the agency's Nursing Home Quality Initiative, CMS received input from the Centers for Disease Control and Prevention (CDC) and two of the nation's largest nursing home industry trade groups, the American Association of Homes and Services for the Aging and the American Health Care Association, in developing the proposed rule.

"Improving immunization is a key element of our quality improvement strategy—a strategy that is focused on preventing illnesses and complications in the first place," said Mark B. McClellan, M.D., Ph.D., administrator of CMS. "The outstanding commitment of the nursing home industry, caregivers and other stakeholders makes clear that this commitment to better quality through more effective immunization is shared and achievable.

"As a physician, I know the impact that influenza and pneumococcal infections can have on the elderly, particularly those in nursing homes," he added. "Greater use of flu shots and pneumococcal vaccine in nursing homes is a proven approach to better health and fewer costly complications for one of our most vulnerable groups of beneficiaries."

In its collaborative effort to improve quality of care, CMS is also encouraging nursing homes to provide influenza vaccine to their healthcare workers. Although the vaccine for these workers will not be required in the final regulation, immunizing nursing home workers has been shown to reduce mortality rates among residents of long-term care facilities. Research from last year's flu season revealed that only 36 percent of all healthcare workers were vaccinated against the illness.

A 1999 national nursing home survey showed that 65 percent of residents had documented influenza shots and only 38 percent had been inoculated against bacterial pneumonia. A goal of this proposed rule is to attain a target rate of 90 percent for both vaccinations. As an added incentive to increase immunization rates, in January, CMS increased the average Medicare payment rate for administering each shot from $8 to $18, in addition to a separate payment for the cost of the vaccine. Medicaid payment rates are set independently by each state.

As a Medicare condition of participation, the rule requires that long-term care facilities ensure that each resident is:

- offered influenza immunization annually;
- immunized against influenza unless medically contraindicated or when the resident or the resident's legal representative refuses immunization;
- offered pneumococcal immunization once if there is no history of immunization; and
- immunized against pneumococcal disease unless medically contraindicated or when the resident or the resident's legal representative refuses immunization.

In the case of a vaccine shortage as declared by CDC, state survey agencies would have the

discretion not cite facilities for being out - of- compliance with this requirement.

"Vaccines against these diseases are effective in preventing hospitalizations and death," said Dr. McClellan. "However, many at-risk people are not getting the vaccines they need. This initiative will be critical to maintaining high-quality care in the nation's long-term care facilities."

Influenza and Pneumococcal Immunization Toolkit available online at:

http://www.medqic.org/dcs/ContentServer?cid=1105558764854&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools

ELECTRONIC FILE VERSION OF CMS-855 NO LONGER AVAILABLE

Effective September 16, 2005, the Centers for Medicare & Medicaid Services (CMS) discontinued supporting the electronic file version of the provider/supplier enrollment applications (i.e., CMS-855). This electronic file format allowed providers and suppliers to complete a provider/supplier enrollment application using their computer and to save their information for future use to report changes.

The CMS removed the electronic file format of the provider/supplier enrollment applications based on information from the Medicare contractors that the public is not utilizing this file format in significant volume to warrant our continued support. Moreover, this decision is supported by numerous reports from the public regarding technical problems using this electronic format. Finally, CMS is making progress in developing and revising its existing provider enrollment applications and the development of a web-based provider enrollment system.

The CMS will continue to support and maintain a PDF version of the provider and supplier enrollment applications. These enrollment applications can be found at http://www.cms.hhs.gov/providers/enrollment/forms/.

HELPFUL WEB SITES

Access Indiana:
http://www.in.gov/

Indiana Secretary of State:
http://www.in.gov/sos/

State Forms Online PDF Catalog:
http://www.state.in.us/icpr/webfile/formsdiv/index.html

Centers for Medicare and Medicaid Services:
http://www.cms.hhs.gov/

AdminaStar Federal:
http://www.adminastar.com

Family and Social Services Administration – Aging:
http://www.in.gov/fssa/elderly/

Family and Social Services Administration – Healthcare:
http://www.in.gov/fssa/healthcare/

Indiana Medicaid:
http://www.indianamedicaid.com/ihcp/index.asp

US Government Printing Office:
http://www.gpo.gov/

Indiana State Police:
http://www.in.gov/isp/

MDS Web Sites:
http://www.cms.hhs.gov/medicaid/mds20/
(includes links for new Section W)

Prevention and Control of Influenza
http://www.cdc.gov/mmwr/pdf/rr/rr5408.pdf

Prevention of Pneumococcal Disease
http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm

Survey and Certification Letters
http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp

REVISED QMA RULES

The QMA rule amendments were signed by the Secretary of State on October 14, 2005. The rule will be effective on November 14, 2005. **See Insert Pg. 37.**

Facts About Invasive Pneumococcal Disease for Adults

- Invasive pneumococcal disease can be prevented with a safe, effective vaccine.
- You cannot get pneumococcal disease from the vaccine.
- Pneumococcal vaccine is fully covered by Medicare Part B if the healthcare provider accepts the Medicare-approved amount.
- Pneumococcal vaccine can be given at any time during the year.
- Pneumococcal vaccine can be given at the same time as influenza vaccine.
- Each year in the U.S., pneumococcal disease accounts for 41,000 cases of bacteremia (bloodstream infection) and meningitis (inflammation of the tissues and fluids surrounding the brain and spinal cord).
- Only 56% of non-institutionalized adults 65 years of age or older, and less than 20% of adults in other high risk groups who should get the pneumococcal vaccine, have received it.
- A single dose of pneumococcal vaccine is recommended for most persons aged 65 years or older. Some people who were younger than 65 when they received the pneumococcal vaccine may need a second dose at age 65.

What is invasive pneumococcal disease?

Pneumococcal disease is an infection caused by a type of bacteria called *Streptococcus pneumoniae*. When these bacteria invade the lungs, they can cause pneumonia. They can also invade the bloodstream (bacteremia) and/or the tissues and fluids surrounding the brain and spinal cord (meningitis). Invasive pneumococcal disease kills thousands of people in the United States each year, most of them 65 years of age or older.

Symptoms

The symptoms of pneumococcal meningitis include stiff neck, fever, mental confusion and disorientation, and photophobia (visual sensitivity to light). The symptoms of pneumococcal bacteremia may be similar to some of the symptoms of pneumonia and meningitis, along with joint pain and fever and chills.

Prevention

There is a vaccine to protect adults against invasive pneumococcal disease. The vaccine is safe and effective. A single dose of the pneumococcal vaccine protects against the 23 different types of *Streptococcus pneumoniae* bacteria that are responsible for causing greater than 90% of all pneumococcal disease cases.

Who should get pneumococcal vaccine?

People who are 65 years of age or older. People two years of age or older who have a chronic illness such as cardiovascular or pulmonary (lung) diseases, sickle cell disease, diabetes, alcoholism, chronic liver diseases, or cerebrospinal fluid (CSF) leaks.

People with a weakened immune system due to illnesses such as HIV infection, AIDS, chronic renal failure, organ transplantation, Hodgkin's disease, lymphoma, multiple myeloma, and those who have had their spleen removed or whose spleen is dysfunctional due to an illness such as sickle cell disease.

People in nursing homes or other long-term care facilities and certain Native American or Alaska Native populations.

Vaccine Safety

The pneumococcal vaccine is safe and effective in preventing illness and death due to pneumococcal disease. Some people have experienced mild side effects, but these are usually minor and last only a short time. When side effects do occur, the most common include swelling and soreness at the injection site. A few people experience fever and muscle pain. As with any medicine, there are very small risks that serious problems could occur after getting the vaccine. However, the potential risks associated with pneumococcal disease are much greater than the potential risks associated with the pneumococcal vaccine. You cannot get pneumococcal disease from the vaccine.

For more information, contact the National Foundation for Infectious Diseases, 4733 Bethesda Avenue, Suite 750, Bethesda, MD 20814, Telephone (301) 656-0003, Web site http://www.nfid.org.

Indiana State Department of Health

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Indiana State Department Of Health
Division of Long Term Care

TELEPHONE GUIDE

Arranged alphabetically by subject

All are Area Code 317

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CNA Investigations	Zetra Allen	233-7772
CNA/QMA Training	Nancy Adams	233-7480
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	Voicemail	233-5359
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MDS Technical Help Desk	Technical Help Desk Staff	233-7206
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Reporting	Tom Reed	233-7541
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Web Site Information	Sarah Roe	233-7904

AREA SUPERVISORS

Area 1	Judi Navarro	233-7617
Area 2	Brenda Buroker	233-7080
Area 3	Vacant	---
Area 4	Zetra Allen	233-7772
Area 5	Karen Powers	233-7753
Area 6	Pat Nicolaou	233-7441
Life Safety Code	Rick Powers	233-7471
ICF/MR North	Brenda Meredith	233-7894
ICF/MR South	Steve Corya	233-7561

Updated 10/2005

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-38

DATE: **July 14, 2005**

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Life Safety Code Survey Issues in Nursing Homes

Letter Summary

- This letter addresses several Life Safety Code survey issues including wardrobe/closet sprinkler requirements, exit discharge surfacing requirements and canopy sprinkler requirements.

The purpose of this memorandum is to clarify the Centers for Medicare & Medicaid Services' (CMS) policy regarding several Life Safety Code (LSC) issues dealing with the sprinklering of wardrobes/closets, the requirements for surfacing of exit discharge pathways, and the requirements for the sprinklering of canopies in nursing homes. CMS recently received inquiries concerning these issues and requesting clarification of previous interpretations of these requirements.

Q1: Does CMS require wardrobe/closet units found in nursing home resident rooms to have a sprinkler head installed in them?

A1: No. CMS does not require that freestanding portable wardrobe units used as a closet to store clothing and other resident personal belongings have a sprinkler installed within them. These units are considered furniture and may be attached to the wall for safety reasons. As a piece of furniture they would not be required to have a sprinkler head installed in the interior of the wardrobe.

The fuel load contained in a closet/wardrobe unit that is a hanger width in depth and has no shelves or drawers internally, may be such that the sprinklers already installed in the room would be adequate and no additional sprinklers would be required in the room.

Surveyors should review the sprinkler coverage provided to ensure that complete and unobstructed coverage from nearby sprinkler heads is provided to the exterior of the wardrobe. This is in accordance with NFPA 13, Installation of Sprinkler Systems, 1999 edition.

Q2: Are exit discharges required to have a hard surface pathway to the public way? This is in reference to tag K-38 and previous guidance.

A2: Previous interpretive guidance on this subject dated 07/07/93 (under tag K-32) is still acceptable. In that guidance we stated that our response to the question was "Yes, if there is much rain or snow and if patients are expected to exit or be evacuated in wheelchairs or beds." This would include residents using walkers. Grass or soil may be acceptable if weather conditions permit. This determination is left up to the judgment of the surveyor as to the local weather conditions and the difficulty that a resident or patient may encounter while traversing between the building and the public way.

Section 7.7.1 NFPA 101 of the LSC (2000 edition) requires that "Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way." An appendix note to 7.7.1 states that the exit discharge is not required to be paved but that it must give safe access to a public way and references section 7.1.10.

Section 7.1.10 of NFPA 101 of the LSC (2000 edition) requires that the means of egress be continuously maintained free of all obstructions or impediments to full and instant use in the case of fire or emergency. An appendix note to 7.1.10 specifically points out that accumulations of snow and ice are an impediment to free movement in the means of egress.

CMS believes that a usable exit discharge is a fundamental and important life safety feature and contributes to the safety of staff and residents in an emergency. The use of the Fire Safety Evaluation System (FSES) is inappropriate as there is no equivalent to being able to exit the building at all times in an emergency.

Q3: Is sprinkler protection required for a canopy constructed of noncombustible materials, such as a weather cover for pedestrian use or the loading or unloading of automobiles at a front entrance?

A3: No. Section 5-13.8.1 of NFPA 13, Installation of Sprinkler Systems, 1999 edition requires exterior roofs or canopies exceeding 4ft in width to have sprinklers installed under them. There is an exception to this requirement that allows for sprinklers to be omitted from certain canopies or roofs. Sprinklers are not required to be installed where a canopy or roof is constructed of noncombustible or limited combustible construction. The reference to noncombustible or limited combustible construction refers to the entire canopy assembly and not just the exposed surfaces. Canopies less than 4 feet in width are not required to be sprinklered regardless of construction type provided no combustibles are stored beneath them. Section 5-13.8.2 of NFPA 13, Installation of Sprinkler Systems, 1999 edition requires that sprinklers be installed under roofs or canopies where combustibles are stored and handled.

Automobiles stopping briefly to load or unload passengers is not considered storage or handling of combustibles and is acceptable. Canopies less than 4 feet in width are not required to be sprinklered regardless of construction type provided no combustibles are stored beneath them.

We hope that this information is useful in clarifying these issues, we will issue other guidance as the need arises in the future.

If you have further questions regarding this matter, please contact James Merrill at (410) 786-6998.

Effective Date: The information contained in this memorandum is current policy and is in effect for all nursing home facilities. The SA should disseminate this information within 30 days of the date of this memorandum.

Training: This clarification should be shared with all survey and certification staff, fire authorities, surveyors, their managers, and the state/RO training coordinator.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-41

DATE: **August 18, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Nursing Homes** - Issuance of Technical Corrections to Appendix PP, State Operations Manual (SOM), Survey Protocol for Long Term Care Facilities

Letter Summary

- This memorandum announces that technical corrections are being made to Appendix PP of the SOM including correction of errors, adding new regulatory text, and moving selected language between tags.
- This is being submitted for immediate issuance; **we are enclosing only the transmittal cover sheet that includes a summary of the changes and not the revised Appendix PP itself, due to its large size.**

The purpose of this memorandum is to notify you that we have made a set of technical corrections to several sections of Appendix PP of the SOM. Overall, the changes included adding new regulatory language, correcting errors (such as missing text), and moving certain regulatory language that had been added to 483.15 (Quality of Life) back to former locations. For detailed changes please see the enclosed transmittal.

For questions on this memorandum, please contact Linda O'Hara (410-786-8347, or email linda.ohara@cms.hhs.gov).

Effective Date: The SA should disseminate this information within 30 days of the date of this memorandum.

Training: The information contained in this announcement should be shared with all nursing home surveyors and supervisors.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Enclosure – Transmittal Cover Sheet with Summary of Changes Only

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal **Date:**

SUBJECT:

I. SUMMARY OF CHANGES:
NEW/REVISED MATERIAL - EFFECTIVE DATE*:
IMPLEMENTATION DATE: Immediately

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix PP, 483.10(l) regulation and guidance was moved from F252 to Section 483.10
R	Appendix PP, Tag 172, Interpretive Guidelines, Par. 1, sentence changed.
R	Appendix PP, Tag 223, Interpretive Guidelines, last Par. added.
D	Erroneous regulatory number (1) was deleted from these regulations 483.13(c)(2), 483.13(c)(3) and 483.13(c)(4).
R	Appendix PP, Tag 225, language added in Interpretive Guidelines, at end.
D	Appendix PP, Tag 315, deleted outdated language at 483.25(d)
R	Appendix PP, Tag 329, missing language restored in Interpretive Guidelines, Par. 1, and the title "Interpretive Guidelines" was restored as well.
D	The first par. of Appendix PP, Tag 429, which refers to the now defunct Appendix N, was deleted.
R	Appendix PP, 483.70(a), regulatory language revised and new portions added per 42 CFR 2004 changes and 2005 changes
R	Appendix PP, 483.70(c)(1), (d), and (d)(2) were moved from Tag 246 to Section 483.70
R	Appendix PP, Tags 464-466, regulatory language was moved among these tags to correct an error in placement of text.

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
x	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-46

DATE: **September 22, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Home Compliance with the Requirements Related to Preventing Abuse

Letter Summary

This memorandum asks all State Survey Agencies (SAs) to remind all Medicare and Medicaid participating nursing homes in the State of the Federal requirements related to screening potential employees and checking with all appropriate nurse aide registries. This memorandum also provides contact information for nurse aide registries in every State.

Competent and caring nurse aides are essential to providing quality care to nursing home residents. Nursing homes have the responsibility to employ qualified nurse aides who are properly trained, appropriately tested, and have no adverse findings against them of abuse, neglect, or misappropriation of property. The purpose of this memorandum is to remind nursing homes of the responsibilities related to screening potential hires, including the responsibility to check the nurse aide registry.

Nursing homes are required to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, and misappropriation of their property. This responsibility includes screening potential employees for a history of abuse, neglect or mistreating residents by obtaining information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries.

Nursing homes are required to check the nurse aide registry. Current Federal regulations prohibit nursing homes from employing individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have had a finding entered into the State nurse aide registry concerning resident abuse, neglect or misappropriation of property. In addition, nursing homes must check the nurse aide registries of other States the potential employer believes might contain information about an individual. The regulations require that before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Social Security Act the facility believes will include information on the individual.

To support this nursing home responsibility, attached is a list of contact information for all State nurse aide registries that may assist nursing home employers in verifying information from other nurse aide registries. The Centers for Medicare & Medicaid Services (CMS) will post the attached list at its link to the Web site, "Sharing Innovations in Quality (SIQ) Repository of Clinical Standards and Quality."

Users can access the repository of information through the current Web site address - http://www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp. The attached State Nurse Aide Registry List is located under the CMS Policies and Memos section of the repository. States are asked to review the registry list and to e-mail any corrections or updated information to siq@air.org. Please reference the e-mail as "Update to the State Nurse Aide Registry List." We hope that this will further assist nursing homes in contacting the nurse aide registry of other States before hiring a nurse aide.

Also, we want to remind nursing homes that Federal regulations allow individuals enrolled in an approved nurse aide training and competency evaluation program to work up to four months, performing only those skills for which their trainer has determined proficiency, before successfully passing their nurse aide competency evaluation examination and being included on the nurse aide registry.

Effective date: Please share this information with all nursing homes in the State within 30 days of the date of this memorandum.

Training: This memorandum should be shared with State Survey Agencies and CMS Regional Office supervisory and training staff.

/s/
Thomas E. Hamilton

Attachment

cc: Survey and Certification Regional Office Management

STATE NURSE AIDE REGISTRY LIST

(To update the information for your agency, please e-mail changes to siq@air.org. Please reference the e-mail as "Update to the State Nurse Aide Registry List.")

ALABAMA AL Nurse Aide Registry AL Dept. of Public Health Division of Healthcare Facilities PO Box 303017 Montgomery, AL 36130-3017 Phone: (334) 206-5169 FAX: (334) 206-5219 Online NAR: http://ph.state.al.us/nar/find.asp Online Abuse List: http://ph.state.al.us/nar/nurse%20aide%20abuse%20list.pdf	**ALASKA** AK Nurse Aide Registry AK Dept. of Commerce, Community & Economic Development Division of Occupational Licensing 550 West 7th Avenue, Suite 1500 Anchorage, AK 99501 Phone: (907) 269-8169 Fax: (907) 269.8196 Online NAR: http://www.commerce.state.ak.us/occ/pnua.htm	**ARIZONA** AZ Nurse Aide Registry AZ State Board of Nursing Nurse Aide Registration Program 1651 E. Morten Ave, Suite 210 Phoenix, AZ 85020 Phone: (602) 889-5150 FAX: (602) 889-5155 Online NAR: http://www.azbn.org/OnlineVerification.asp
ARKANSAS AR Nurse Aide Registry AR Dept. of Human Services Office of Long-term Care PO Box 8059, Slot S405 Little Rock, AR 72203-8059 Automated Line: (501) 682-8484 Direct Line: (501) 682-1807 FAX: (501) 682-8551	**CALIFORNIA** CA Nurse Aide Registry CNA/HHA/CHT Certification Unit Licensing & Certification Program ATCS-MS 3301 P.O. Box 997416 1615 Capitol Avenue Sacramento, CA 95899-7416 Phone: (916) 327-2445 Fax: (916) 552-8785	**COLORADO** CO Nurse Aide Registry Colorado Board of Nursing 1560 Broadway, Suite 880 Denver, CO 80202 Phone (303) 894-2442 Fax: (303) 894-2821 Online NAR: https://www.doradls.state.co.us/alison.php
CONNECTICUT CT Nurse Aide Registry CT Dept. of Public Health 410 Capitol Avenue, MS# 12 MQA PO Box 340308 Hartford, CT 06134-0308 Phone: (860) 509-7596 FAX: (860) 509-7607 Registry Managed by Promissor PO Box 13785 Philadelphia, PA 19101 Phone: (800) 566-8668 Online NAR: www.asisvcs.com/services/registry/search_generic.asp?CPCat=0607NURSE	**DELAWARE** DE CNA Registry DE Dept. of Health and Social Services Div. Long Term Care Residents Protection 3 Mill Road, Suite 308 Wilmington, DE 19806 Phone: (302) 577-6666 Verification: (302) 577-6666 Online Registry: Managed by D&S Diversified, Headmaster, LLP www.hdmaster.com	**DISTRICT OF COLUMBIA** DC Nurse Aide Registry DC Dept. of Health Health Regulation Administration Child & Residential Care Facilities Division 825 North Capitol Street, NE, 2nd Floor Washington, DC 20002 (202) 442-5877 Registry Managed by Promissor PO Box 13785 Philadelphia, PA 19101-3785 Phone: (888) 274-6060 Online NAR: https://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0709NURSE
FLORIDA FL Nurse Aide Registry FL Dept. of Health MQA/CNA Program 4052 Bald Cypress Way BIN # C13 Tallahassee, FL 32399-3263 Registry Line: (850) 245-4567 Exemption Line: 850-245-4125 FAX: (850) 488-4281 Online NAR: http://ww2.doh.state.fl.us/cnanet/cnalist.aspx	**GEORGIA** GA Nurse Aide Registry GA Health Partnership - GMCF 1455 Lincoln Parkway East, Suite 750 Atlanta, GA 30346-2200 Phone: (678) 527-3010 (local) or (800) 414-4358 FAX: (678) 527-3001 Online NAR: www.ghp.georgia.gov	**HAWAII** HI Nurse Aide Registry HI Dept. of Commerce & Consumers Affairs Professional & Vocational Licensing Branch PO Box 3469 Honolulu, HI 96816 Phone: (808) 734-586-3000 FAX: (808) 734-8318

IDAHO ID Nurse Aide Registry ID Dept. of Health & Welfare Division of Medicaid Bureau of Facility Standards PO Box 83720 Boise, ID 83720-0036 Phone: (208) 334-334-6620 FAX: (208) 334-6629 Managed by D&S Diversified, Headmaster, LLP Online NAR: http://206.127.65.98/cgi-bin/CGIServer/root?StateAbbrv=ID	**ILLINOIS** IL Nurse Aide Registry IL Dept. of Public Health Education & Training Section 525 W. Jefferson Street Springfield, IL 62761 Phone: (217) 785-5133 Verification: (217) 782-3070 FAX: (217) 782-0382 Online NAR: http://app.idph.state.il.us/nar/index.htm	**INDIANA** IN Nurse Aide Registry IN State Department. of Health Division of Long Term Care 2 N Meridian Street, Section 4B Indianapolis, IN 46204 Phone: (317) 233-7351 Verification: (317) 233-7612 FAX: (317) 233-7750 Online NAR: www.in.gov/isdh/regsvcs/acc/certhha/
IOWA IA Direct Care Worker Registry IA Dept. of Inspections & Appeals Health Facilities Division Lucas State Office Building Des Moines, IA 50319-0083 Phone: (515) 281-4077 FAX: 515-242-5022 Verification: (866) 876-1997 Online NAR: https://dia-hfd.iowa.gov/DIA_HFD/Home.do	**KANSAS** KS Nurse Aide Registry KS Dept. of Health & Environment Health Occupations Credentialing 1000 SW Jackson Street, Suite 200 Topeka, KS 66612-1365 Verification: (785) 296-6877 Registry: (785) 296-0059 FAX: (785) 296-3075 Online Abuse List: http://www.kdhe.state.ks.us/hoc/abuse_neglect_exploitation/index.html Online NAR: http://www.ksnurseaidregistry.org/	**KENTUCKY** KY Nurse Aide Registry KY Board of Nursing 312 Whittington Parkway, Suite 300-A Louisville, KY 40222 Phone: (502) 329-7047 FAX: (502) 696-3955 Online NAR: ssla.state.ky.us/KBN/kbnknar.asp ($1.00 charge per nurse aide query)
LOUISIANA LA Nurse Aide Registry LA State Board of Examiners for Nursing Facility Administrators 5647 Superior Drive Baton Rouge, Louisiana 70816 Phone: (225) 295-8575 FAX: (225) 295-8578 Online NAR: www.labenfa.com/naidesreg/	**MAINE** ME Registry of Certified Nurse Aides ME Dept. of Human Services Division of Licensing & Certification State House Station #11 442 Civic Center Drive Augusta, ME 04330 Phone: (207) 287-9310 FAX: (207) 287-9325	**MARYLAND** MD Nurse Aide Registry MD Board of Nursing 4140 Patterson Avenue Baltimore, MD 21215-2254 Phone: (410) 585-1900 FAX: (410) 585-8042 Online NAR: https://12.153.47.224/
MASSACHUSETTS MA Nurse Aide Registry MA Dept. of Public Health Division of Health Care Quality 10 West Street Boston, MA 02111 Phone: (617) 753-8143 Verification: (617) 753-8192 FAX: (617) 753-8096	**MICHIGAN** MI Nurse Aide Registry MI Dept of Community Health Bureau of Health Professions PO Box 30670 Lansing, MI 48909 Phone: (517) 241-0554 Registry Managed by: The Chauncey Group International 664 Rosedale Road Princeton, NJ 08540 Verification: (800) 748-0252 Online NAR: www.chauncey.com/State_Nurse_Aide/michigan.htm	**MINNESOTA** MN Nursing Assistant Registry MN Dept. of Health 85 E 7th Place, Suite 300 PO Box 64501 St. Paul, MN 55164-0501 Phone: (651) 215-8705 (800) 397-6124 (in state only) FAX: (651) 215-8709

MISSISSIPPI MS Nurse Aide Registry MS Dept. of Health Health Facilities Licensure & Certification 570 East Woodrow Wilson (zip 39216) Osborne Building, Suite 200 PO Box 1700 Jackson, MS 39215-1700 Phone: (601) 576-7300 Registry Managed by Promissor PO Box 13785 Philadelphia, PA 19101-3785 Phone: (888) 204-6213 Online NAR: www.Promissor.com (Registry Services/MS Nurse Aides/Search the Registry)	**MISSOURI** MO Nurse Aide Registry MO Dept. of Health & Senior Service Division of Health Health Education Unit PO Box 570 3418 Knipp Jefferson City, MO 65102 Phone: (573) 751-3082 Verification: (573) 526-5686 FAX: (573) 526-7656	**MONTANA** MT Nurse Aide Registry MT Dept. of Public Health & Human Services Certification Bureau Nurse Aide Registry PO Box 202953 2401 Colonial Drive, 2nd Floor Helena, MT 59620-2953 Phone: (406) 444-4980 FAX: (406) 444-3456 Online NAR: http://161.7.8.64/QAD/nurseaideregistry.jsp
NEBRASKA NE Nurse Aide Registry NE Dept. Health & Human Services Regulation & Licensure Credentialing Division PO Box 94986 Lincoln, NE 68509-4986 Phone: (402) 471-0537 Verification: (402) 471-0537 FAX:(402) 471-1066 Online NAR: http://www.nebraska.gov/LISSearch/search.cgi	**NEVADA** NV Nurse Aide Registry NV State Board of Nursing 5011 Meadow Mall Way, # 201 Reno, NV 89502-6547 Phone: (775) 688-2620 or (800) 746-3980 Verification: (888) 590-6726 FAX: (775) 688-2628 Online NAR: http://www.nursingboard.state.nv.us/verification/formLicense.html	**NEW HAMPSHIRE** NH Nurse Aide Registry NH Board of Nursing 21 South Fruit Street, Suite 16 Concord, NH 03301-2431 Phone: (603) 271-6282 or (603) 271-2323 Verification: (603) 271-6599 FAX: (603) 271-6605 Online NAR: http://www.nhlicenses.nh.gov/WebLookUp/
NEW JERSEY NJ Nurse Aide Registry NJ Dept. Health & Senior Services Division of Long Term Care Systems PO Box 367 Trenton, NJ 08625-0367 Phone: 609) 633-9171 Fax: (609) 341-3552 Registry managed by Promissor PO Box 13785 Philadelphia, PA 19101-3785 Phone: (800) 274-8970 Online NAR: https://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0631NURSE	**NEW MEXICO** NM Nurse Aide Registry NM Dept. of Health 1421 Luisa Street Suite R Sante Fe, NM 87505 Phone: (505) 827-1453 FAX: (505) 827-1419 Online NAR: http://dhi.health.state.nm.us/nar/index.php	**NEW YORK** NY Nurse Aide Registry NY State Dept. of Health Bureau of Professional Credentialing 161 Delaware Delmar, NY 12054-1393 Phone: (518) 408-1297 Registry Managed by: Thomson Prometric (Formerly The Chauncey Group International) 664 Rosedale Road Princeton, NJ 08540 Verification: (800) 918-8818 Online NAR: www.nynar.chauncey.com
NORTH CAROLINA NC Nurse Aide Registry (Nurse Aide 1) NC Dept. of Health & Human Services Division of Facility Services 2709 Mail Service Center Raleigh, NC 27699-2709 Phone: (919) 855-3969 Verification: (919) 715-0562 FAX: (919) 733-9764 Online NAR: www.ncnar.org/verify_listings.jsp	**NORTH DAKOTA** ND Nurse Assistant Registry ND Dept. of Health Division of Health Facilities 600 East Boulevard Avenue, Dept. 301 Bismarck, ND 58505-0200 Phone: (701) 328-2353 FAX: (701) 328-1890 Online Abuse List Only http://www.health.state.nd.us/hf/North_Dakota_certified_nurse_aide.htm	**OHIO** OH Nurse Aide Registry OH Dept. of Health 246 North High Street, 3rd Floor Columbus, OH 43215-2412 Verif: (outside OH): (614) 752-9500 Verif (OH Residents only): (800) 592-5908 FAX: (614) 995-5085 Online NAR: https://odhlogin.odh.ohio.gov/nar/nar_registry_search.aspx

OKLAHOMA OK Nurse Aide Registry OK State Dept. of Health 1000 NE 10th Street Oklahoma City, OK 73117-1299 Phone: (800) 695-2157 or (405) 271-4085 FAX: (405) 271-1130 Online Abuse Registry: www.health.state.ok.us/program/nrsaid/Abusewww.pdf	**OREGON** OR Nurse Aide Registry OR State Board of Nursing 800 NE Oregon Street, Suite 465 Portland, OR 97232 Phone: (503) 731-3459 Verification: (503) 731-3459 FAX: (503) 731-4755 Online NAR: http://my.oregon.gov/search/searchResults-submit.do#	**PENNSYLVANIA** PA Nurse Aide Registry PA Dept. of Health Division of Nursing Care Facilities Room 526, H@W Bldng. 7th and Forster Streets Harrisburg, PA 17120 (717) 783-8973 Registry Managed by Promissor PO Box 13785 Philadelphia, PA 19101-3785 Phone: (800) 852-0518 FAX: (610) 617-9398 Online NAR: https://www.asisvcs.com/services/registry/search_fs.asp?CPCat=0639NURSE
RHODE ISLAND RI Nurse Aide Registry RI Dept. of Health Professionals 3 Capitol Hill, Room 105 Providence, RI 02908-5097 Phone: (401) 222-5888 FAX: (401) 222-3352 Online Abuse Verif: http://www.health.ri.gov/hsr/professions/n_assist_discip.php	**SOUTH CAROLINA** SC Nurse Aide Registry SC Dept. of Health & Environment Control 2600 Bull Street Columbia, SC 29201 Phone: (803) 545-4205 Registry Managed by Promissor PO Box 13785 Philadelphia, PA 19101-3785 (800) 475-8290 Online NAR: www.asisvcs.com/services/registry/search_generic.asp?CPCat=0741NURSE	**SOUTH DAKOTA** SD Nurse Aide Registry SD Board of Nursing 4305 South Louise Avenue, Suite 201 Sioux Falls, SD 57106 Phone: (605) 362-2760 FAX: (605) 362-2768
TENNESSEE TN Nurse Aide Registry TN Dept. of Health Division of Health Care Facilities Cordell Hull Building, 1st Floor 425 5th Avenue North Nashville, TN 37247-0508 Phone: (888) 778-4504 FAX: (615) 248-3601 Online NAR: www2.state.tn.us/health/licensure/index.htm Online Abuse Registry: www2.state.tn.us/health/abuseregistry/index.html	**TEXAS** TX Nurse Aide Registry TX Dept. of Aging & Disability Services Licensing & Credentialing Regulatory Services PO Box 149030, MC W-240 Austin, TX 78714-9030 Phone: (512) 231-5829 FAX: (512) 231-5858 Verification: (800) 452-3934 or http://www.asisvcs.com/indhome.asp?CPCat=0644NURSE Online Sanction Registry www.dads.state.tx.us/business/ltcr/credentialing/sanctions/output.cfm	**UTAH** UT Nurse Aide Registry UT Health Technology Certification Center 550 E. 300 South Kaysville, UT 84037 Phone: (801) 547-9947 FAX: (801) 593-2400 Online NAR: http://206.127.65.98/cgi-bin/CGIServer/root?StateAbbrv=UT
VERMONT VT Nurse Aide Registry VT State Board of Nursing Heritage Building 81 River Street Montpelier, VT 05609 Phone: (802) 828-2819, (802) 828-2453, or (802) 828-2396 FAX: (802) 828-2484 Online NAR: www.vtprofessionals.org	**VIRGINIA** VA Nurse Aide Registry VA Board of Nursing 6603 W. Broad Street, 5th Floor Richmond, VA 23230 Phone: (804) 662-7310 FAX: (804) 662-9512 Online NAR: http://www2.vipnet.org/dhp/cgi-bin/search_publicdb.cgi	**WASHINGTON** WA OBRA Nurse Aide Registry Aging & Adult Services Administration Residential Care Services Division 640 Woodland Square Loop SE PO Box 45600 Olympia, WA 98504-5600 Phone: (360) 725-2570 FAX: (360) 493-2581

WEST VIRGINIA	WISCONSIN	WYOMING
WV Nurse Aide Registry WV Division of Health Office of Health Facilities Licensure & Certification 1 Davis Square, Suite 101 Charleston, WV 25301-1799 Phone: (304) 558-0688 FAX: (304) 558-1442 Online NAR: www.wvdhhr.org/ohflac/NurseAide/nalookup/NALookup.Asp	WI Nurse Aide Registry WI Dept. Health & Family Services Bureau of Quality Assurance Office of Caregiver Quality 2917 International Lane, Suite 300 Madison, WI 53704 Phone: (608) 243-2019 FAX: (608) 243-2020 Registry Managed by Promissor PO Box 13785 Philadelphia, PA 19101-3785 Phone: (877) 329-8760 Online NAR: https://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0750NURSE Online Caregiver Misconduct Registry: www.dhfs.state.wi.us/caregiver/misconduct.HTM	WY Nurse Aide Registry WY Board of Nursing 2020 Carey Avenue, Suite 110 Cheyenne, WY 82002 Phone: (307) 777-7601 Verification: (877) 626-2681 FAX: (307) 777-3519

Medicare Learning Network

Medlearn Matters

Information for Medicare Providers

CMS

Medlearn Matters Number: SE0555

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Revised: This article was revised on October 3, 2005, to modify the language (in italicized print) in the first sentence under Part 2 on Page 5. All other information remains the same.

Table of Contents

Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition Medlearn Matters Articles on NPI-Related Activities

Provider Types Affected

Providers and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain NPIs for those providers should take note of this article.

Part 1: Information That Applies to All Providers

Background

All healthcare providers are eligible to receive NPIs. All HIPAA covered healthcare providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use **only** the NPI to identify covered healthcare providers in standard transactions by **May 23, 2007**. Small health plans must use **only** the NPI by **May 23, 2008**.

Obtaining and Sharing Your NPI

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) web site, **https://nppes.cms.hhs.gov.** The NPPES is the only source for NPI assignment.

The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Healthcare providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

- An easy web-based application process is available at **https://nppes.cms.hhs.gov**.
- A paper application may be submitted to an entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available at **https://nppes.cms.hhs.gov**. A copy of the paper application may also be obtained by calling the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies

Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that they are ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies);
- Health plans with which they conduct business; and
- Organizations where they have staff privileges.

We understand that providers have many questions related to EFI or bulk enumeration, NPPES Data Dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The EFI Steps

Once EFI is available, concerned entities will follow these steps:

- √ An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES web site (**https://nppes.cms.hhs.gov**) and download a certification form.
- √ The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).
- √ Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- √ Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- √ Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- √ The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s). An EFIO may also be used for updates and deactivations, if the providers agree to do so.

National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months. The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

Crosswalks

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of healthcare providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

Subparts of a Covered Organization

Covered-organization healthcare providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI rule calls these entities ***"subparts"*** to avoid confusion with the term healthcare "components" used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be "subparts."

The NPI was mandated to identify each healthcare provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI Final Rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

The NPI Final Rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require healthcare providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, healthcare providers who need billing numbers for federal health programs are actually components of covered healthcare providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

What Providers Can Do to Prepare for NPI Implementation

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.

- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

Part 2: Information that Applies to Medicare Fee-For-Service (FFS) Providers Only

All Medicare providers are reminded that they will be required to use the NPI ***in Medicare claims transactions.***

NPI Transition Plans for Medicare FFS Providers

Medicare's implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table below:

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using only their existing **Medicare** numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 -October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must also be on the claim.** Note that CMS claims processing systems will reject, as unprocessable, any claim that includes **only** an NPI. Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007:	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward:	CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

Crosswalk

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

Subparts Policy

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

Resources for Additional Information

Coming Soon---CMS is developing a Medlearn web page on NPI for Medicare FFS providers, which will house all Medicare fee for service educational resources on NPI, including links to all Medlearn Matters articles, frequently-asked-questions, and other information. CMS will widely publicize the launch of this web page in the coming weeks.

You may wish to visit **http://www.cms.hhs.gov/hipaa/hipaa2/** regularly for the latest information about the NPI, including Frequently Asked Questions, announcements of Roundtables, conferences, and guidance documents regarding the NPI.

Go to
http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available at **http://www.cms.hhs.gov/medlearn/npi/npiviewlet.asp**

The Federal Register notice containing the NPI Final Rule is available at
http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf

There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

You may also find some industry implementation recommendations and white papers on the NPI at **http://www.wedi.org**, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

Medicare Learning Network

Medlearn Matters

Information for Medicare Providers

CMS

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0544

Related CR Release Date: N/A

Message to Nursing Home Administrators on Medicare Prescription Drug Coverage-

The Sixth in the Series of Medlearn Matters Articles on the New Prescription Drug Coverage

Provider Types Affected

Skilled Nursing Facilities (SNFs) - This article contains important information for nursing home staff about the impact of the new prescription drug coverage on people who receive both Medicare and Medicaid.

Information for Nursing Home Administrators

The Centers for Medicare & Medicaid Services (CMS) released the following information via the Minimum Data Set (MDS) submission system's Welcome Page on July 6, 2005:

- Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. Also starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare (also known as Full Benefit Dual Eligibles or FBDEs); instead, prescription drug coverage for people in this group will be provided by Medicare. Since two thirds of residents in nursing homes fall into this category, this Federal program will be critically important. State Medicaid coverage for **health care** coverage is not affected.
- All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid must enroll in a Medicare Prescription Drug Plan to get this coverage. They will receive information from Medicare and from the plans in their area this fall and they will need to choose and enroll in a plan that meets their needs. However, if they haven't joined a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don't miss a day of coverage. People in this group can switch to another plan at any time.

Important Points to Remember

- √ On January 1, 2006, new prescription drug coverage will be available to your Medicare residents. It will cover brand name and generic drugs.
- √ Starting January 1, 2006, state Medicaid programs will no longer provide drug coverage for people also covered by Medicare.
- √ All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid **must** enroll in a Medicare Prescription Drug Plan to get continuous coverage of their prescription drug costs.
- √ If Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid do not enroll in a Medicare Prescription Drug Plan by December 31, 2005, Medicare will enroll them in a plan automatically to make sure they do not miss a day of coverage.
- √ Medicaid beneficiaries who live in a nursing home will pay nothing out of their pocket for Medicare prescription drug coverage.
- √ If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to **http://www.medicare.gov** for additional information and assistance.

- The Centers for Medicare & Medicaid Services (CMS) will use the Minimum Data Set (MDS) distribution system to keep nursing home administrators informed about Medicare prescription drug coverage as it applies to nursing home residents.
- All Medicare prescription drug plans will provide at least a standard level of coverage to all enrollees. Coverage will be available through both Medicare "Prescription Drug Plans" (PDPs), and as part of Medicare Advantage Plans or other Medicare Health Plans (MA-PDs). All plans will be required to cover enrollees in all nursing homes in their regions. They will also be required to meet specific service and performance criteria to ensure safe prescription drug administration in the nursing home setting. While plans may offer different formularies (lists of covered drugs), CMS will require plans to cover a range of drugs in the most commonly prescribed classes to make sure that people with different medical conditions can get the treatment they need.

  An "exceptions and appeals" process will be in place to ensure access to non-formulary drugs. The plans will arrange for medications to be packaged and made available to nursing homes through long-term care pharmacy providers. These will most likely include current pharmacy providers to nursing homes, as well as new organizations that are able to meet the CMS long-term care pharmacy standards. Nursing homes will be able to select from these pharmacy vendors to ensure that all of the residents have appropriate drug coverage.
- People who receive both Medicare and Medicaid and reside in a nursing home will receive continuous prescription drug coverage, with no premiums, no deductibles, and no co-payments.
- People with limited income and resources, who are **not** eligible for full Medicaid benefits, may qualify for extra help paying for Medicare prescription drug coverage. If they qualify, they will receive extra help to pay for premiums, deductibles, and co-payments. They **will** have to pay a copayment or coinsurance amount, depending on their income and resources.
- More information concerning Medicare prescription drug coverage as it applies to the long-term care population, and operational steps that will be necessary to ensure a seamless transition in 2006, will be forthcoming through the MDS distribution system. Additional information and resources are also available at: **http://www.cms.hhs.gov** on the CMS web site.

Additional Information

More information on provider education and outreach regarding Medicare prescription drug coverage can be found at: **http://www.cms.hhs.gov/medlearn/drugcoverage.asp** on the web.

Detailed drug coverage information for CMS partners and beneficiary advocates can be found at **http://www.cms.hhs.gov/partnerships/news/mma/default.asp** on the web.

You can also find additional information regarding prescription drug plans at **http://www.cms.hhs.gov/pdps/** on the web.

The Season for Change

2005 Nursing Home Quality Initiative (NHQI) October Provider Meeting, sponsored by Health Care Excel, Medicare Quality Improvement Organization (QIO) for Indiana.

FREE Continuing Education

Agenda (Central Time Zone)

7:45 a.m. to 8:00 a.m.	Registration *(Setting Targets—Achieving Results [STAR] assistance available)*
8:00 a.m. to 8:05 a.m.	Introduction
8:05 a.m. to 9:05 a.m.	AUTUMN, THE SECOND SPRING Celebrating and Building Relationships
9:05 a.m. to 10:00 a.m.	LEAVES OF CHANGE The Next Three Years of the NHQI
10:00 a.m. to 10:15 a.m.	Break *(STAR assistance available)*
10:15 a.m. to 11:15 a.m.	AUTUMN LEAVES GENTLY FADING Depression: A Team Approach
11:15 a.m. to 11:30 a.m.	"Interview with Steve Shields" (Video)
11:30 a.m. to 12:30 p.m.	Lunch Provided *(STAR assistance available)*
12:30 p.m. to 1:45 p.m.	CHANGING COLORS—CHANGING LIVES Person-centered Care
1:45 p.m. to 2:00 p.m.	Break *(STAR assistance available)*
2:00 p.m. to 3:15 p.m.	CREATING A FOREST WITH ONE ACORN Workforce Retention
3:15 p.m. to 3:45 p.m.	"Celebrate What's Right with the World!" (Video)
3:45 p.m. to 4:00 p.m.	Questions and Answers Evaluations *(STAR assistance available)*

Locations

(For the locations below, register by October 3.)

October 11, 2005
Avalon Manor
3550 East U.S. Highway 30
Merrillville, Indiana
219-945-0888

October 12, 2005
Windsor Park Conference Center
4020 Edison Lakes Parkway
Mishawaka, Indiana
574-271-8060

October 13, 2005
Allen County War Memorial Coliseum
4000 Parnell Avenue
Fort Wayne, Indiana
260-482-9502

(For the locations below, register by October 17)

October 25, 2005
Holiday Inn Conference Center
2480 Jonathan Moore Pike
Columbus, Indiana
812-372-1541

October 26, 2005
Primo West Banquet & Conference Center
2353 Hadley Road
Plainfield, Indiana
317-839-9990

October 27, 2005
Good Samaritan Home
601 N. Boeke Road
Evansville, Indiana
812-476-4912

Facilities are handicap accessible. Special accommodations and dietary requirements will be considered upon request. For additional information, please call the Medicare Provider Help Desk at 1-800-300-8190, or e-mail innursinghome@hce.org.

Registration Form

(Registration Required)

2005 Fall NHQI Provider Meeting Sponsored by Health Care Excel

The Season for Change

Name_____ Title _____ Credentials _____

Organization _____

Business Address _____

City_____ State_____ ZIP Code_____

Telephone_____ Fax_____ E-mail _____

Medicare Provider #_____

Continuing Education Credits Requested (circle one)

Social Worker RN LPN NP Administrator Physician

Professional License #_____

Circle the date that you prefer to attend.

October 11 October 12 October 13 October 25 October 26 October 27

Mail your registration form to: Health Care Excel, Attn: NHQI, P.O. Box 3713
Terre Haute, IN 47803-0713, or fax to 812-232-6167

Is Your Nursing Home a STAR?

Health Care Excel wants your nursing home to be a STAR performer in Indiana. The Centers for Medicare & Medicaid Services (CMS) is expecting all nursing homes nationwide to participate in target setting. How do you accomplish this? Start by setting targets for your facilities for chronic care pain, depression, high-risk pressure ulcers, and physical restraints.

What is STAR?

The nursing home STAR site is a secure Web site available to any nursing home with a computer and an Internet connection. The benefits to using the STAR site, include the following.

- View your nursing home's quality measure trend reports
- Compare your nursing home's performance to state and national peers
- Select confidential performance-based targets
- Track your achievement of targets over time

Setting up a STAR account and setting targets for your nursing home is **FREE** and takes 30 minutes to complete. Health Care Excel's Nursing Home team is available to assist you with setting your targets today—it's that easy! For assistance with STAR call the Medicare Provider Help Desk at 1-800-300-8190.

How to Get Started

Step 1: Set up a STAR account. Below are the instructions on how to do this.

1. Log on to www.nhqi-star.org
2. Click on '**Create an Account**.'
3. Enter your Medicare/Medicaid provider number.
4. The '**My Profile'** page will be displayed.
5. Your facility demographics will be pre-populated in the form on the '**My Profile'** page. If any of the demographics are incorrect, you can correct them.
6. Enter your contact information, a username, and password. Your contact information will be used to send periodic e-mail reminders about target setting.
7. Write down your username and password.
8. Click '**Submit**.'

Step 2: Enter your target settings for chronic care pain, depression, high-risk pressure ulcers, and physical restraints for your facility.

1. Once you create an account, enter the requested user name, password, and contact information to complete your facilities profile. Click '**Save**' to store your information.
2. Click on '**My Data Comparison**' in the left navigation bar to view your facility's QM trend reports. The trend reports show QM data to one-tenth of a percent.

Article Submission

August 31, 2005

Contact Information: Nancy Meadows
Quality Review Educator
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E-mail Address: nmeadows@inqio.sdps.org.

Expedited Determination (ED) Process for Original Medicare

Revised Questions and Answers (Q&As)

As of August 19, 2005, the Centers for Medicare & Medicaid Services (CMS) updated the *ED Process Questions and Answers*. The revised Q&As replace all previous guidance on the new expedited review process. Effective July 1, 2005, Home Health Agencies, Skilled Nursing Facilities, Comprehensive Outpatient Rehabilitation Facilities, and Hospices are required to notify beneficiaries enrolled in Traditional Medicare of their right to the new expedited review process when these providers anticipate that Medicare coverage of their services will end. The revised Q&As are grouped as follows.

General Scope of ED Process in Original Medicare Q&As

Includes: Information on differences in the similar ED processes for Medicare managed care and Original Medicare; Medicare Secondary Payer; Dual Eligibles; differences for providers submitting claims to Medicare carriers and intermediaries.

General Policy on the ED Process Q&As

Includes: Authorized Representatives; Payment Liability; Reduction of Services; Wholly or Partially Non-covered Services; Higher Level of Care; Hospitalizations; Similar Level of Care; Different Providers; Residential to Non-Residential Care; Change of Providers; and Instructions.

Physician Orders/Certification of Risk Q&As

Includes: What settings require certification statement; the QIO role in these processes; physician orders to continue care.

Revised Q&As can be found at the following CMS Web site.

http://www.cms.hhs.gov/medicare/bni/EDqsandas.pdf

Skilled Nursing Facilities (SNFs) will want to pay particular attention to page three of the Q&A revisions that address Part A and Part B covered services. This reflects a change from the original instructions. The Advanced Notice should be given at the time Part A services end, even if Part B coverage continues. A second notice would then be necessary at the cessation of Part B services. (See table on page 4) Triggers for the Advanced Notice will include "end of all Part B services on plan of care". (See Group 7, SNF Services Under Part B for specific examples)

Additional in-depth resources and information of the new expedited review process for beneficiaries in original Medicare also are available at the following CMS Web site. **https://www.cms.hhs.gov/medicare/bni/**

For information on the expedited review process, contact the Medicare QIO Provider Help Desk at 1-800-300-8190, or e-mail **inreview@hce.org.**

IMPORTANT NOTICE
ABOUT YOUR
QUALIFIED MEDICATION AIDE (QMA)
RE-CERTIFICATION

Your QMA certification will expire on March 31, 2006.

To maintain your certification, you must receive a minimum of six (6) hours per year of in-service education in the area of medication administration (if facility policy allows the you to perform medication administration via G-tube/J-tube, hemoccult testing or finger stick blood glucose testing, the in-service must include those procedures). The in-services should be completed by February 28, 2006.

In-services are to be documented on the *Qualified Medication Aide Record of Annual In-service Training* form. Both the in-service training form and $10.00 fee (payable to ISDH) should be submitted to:

Indiana State Department of Health
Cashier's Office
PO Box 7236
Indianapolis IN 46207-7236

If you have questions regarding this process, please call Nancy Adams at 317/233-7480 or Nancy Gilbert at 317/233-7616.

TITLE 412 INDIANA HEALTH FACILITIES COUNCIL

LSA Document #05-35(F)

DIGEST

Amends 412 IAC 2-1-2.1, 412 IAC 2-1-10, and 412 IAC 2-1-14 to establish the effective and expiration dates for qualified medication aide (QMA) certificates, to amend the requirements for certification, recertification, or reinstatement of a QMA, and to amend the fees required for certification, recertification, or reinstatement. Repeals 412 IAC 2-1-13. Effective 30 days after filing with the secretary of state.

412 IAC 2-1-2.1 **412 IAC 2-1-13**
412 IAC 2-1-10 **412 IAC 2-1-14**

SECTION 1. 412 IAC 2-1-2.1 IS AMENDED TO READ AS FOLLOWS:

412 IAC 2-1-2.1 Employment of QMA and registry verification
Authority: IC 16-28-1-11
Affected: IC 16-28

Sec. 2.1. (a) ~~A facility must~~ **An individual shall** not ~~allow an individual to~~ work as a QMA unless that individual**:**

(1) has satisfactorily completed a state-approved QMA training and competency evaluation program**;** and ~~has been~~

(2) **is** certified by the Indiana state department of health.

An individual shall maintain QMA certification as required by subsection 10(c) of this rule in order to continue working as a QMA.

~~(b) A facility must not allow an individual to work as a QMA unless the individual has been recertified and completed at least six (6) hours of in service training per calendar year beginning January 1 of the year after initial training and certification.~~

~~(c)~~**(b)** Before allowing an individual to serve as a QMA, a facility must receive verification from the Indiana Certified Nurse Aide (CNA)/QMA registry that the individual has met certification requirements unless the individual can prove that he or she has**:**

(1) recently successfully completed a QMA training and competency evaluation program approved by the Indiana state department of health**;** and ~~has~~

(2) not yet been included in the registry.

Facilities must follow-up to ensure that such an individual actually is placed in the registry.

(Indiana Health Facilities Council; 412 IAC 2-1-2.1; filed Jan 24, 2003, 8:26 a.m.: 26 IR 1937; errata filed Feb 10, 2003, 3:50 p.m.: 26 IR 2375)

SECTION 2. 412 IAC 2-1-10 IS AMENDED TO READ AS FOLLOWS:

412 IAC 2-1-10 Certification, recertification, reinstatement, and in-service education requirements

Authority: IC 16-28-1-11

Affected: IC 16-28

Sec. 10. (a) A QMA shall be ~~recertified~~ **certified** by the Indiana state department of health ~~every year~~.

(b) ~~To be recertified, a QMA must obtain a minimum of six (6) hours per calendar year of in-service education in the area of medication administration, beginning January 1 of the year after~~ **For** initial ~~QMA training and~~ certification **as a QMA, the individual must do the following:**

(1) Complete the requirements of this rule.

(2) Submit to the testing entity an application approved by the Indiana state department of health.

(3) Pass the written competency test in three (3) or fewer attempts with a passing score of at least eighty percent (80%).

(c) For recertification, at least thirty (30) days before the expiration of the certificate, the individual must do the following:

(1) Obtain a minimum of six (6) hours per year of annual in-service education.

(2) Submit to the Indiana state department of health a qualified medication aide record of annual in-service education on the form approved by the Indiana state department of health.

(3) Submit to the Indiana state department of health the appropriate fee.

The QMA is responsible for completing the in-service education requirements, maintaining documentation of in-service education, and submitting, or ensuring the submission of, the qualified medication aide record of annual in-service education form and appropriate fee.

(d) If the recertification fees or in-service education form, or both, required by subsection (c) is received by the Indiana state department of health more than ninety (90) days after the expiration of the QMA certification, the individual:

(1) is removed from the QMA registry; and

(2) must be reinstated under subsection (e) in order to work as a QMA.

(e) For reinstatement as a QMA following removal from the QMA registry, the individual must do the following:

(1) Complete the requirements of this rule.

(2) Submit to the testing entity an application approved by the Indiana state department of health.

(3) Pass the written competency test in three (3) or fewer attempts with a passing score of at least eighty percent (80%).

~~(c)~~ **(f)** Annual in-service education shall include ~~but is not limited to, the following~~ **medication administration.** If facility policy allows the QMA to perform such functions in the facility, **annual in-service education shall also include the following:**

(1) Medication administration via G-tube/J-tube.

(2) Hemoccult testing.

(3) Finger stick blood glucose testing (specific to the glucose meter used).

~~(d) It is the QMA's responsibility to track said hours of in-service training and supply proof of completion of in-service training to the Indiana state department of health in conjunction with application for annual recertification.~~

(g) QMA certificates:

(1) are effective upon issue;

(2) and expire on March 31 of the next year.

The annual in-service education requirement period begins each year on March 1 and concludes on the last day of February of the next year. In the case of an initial certification, the annual in-service education requirement period begins on the QMA certification effective date and concludes on the last day of February of the next year. The in-service education requirement period therefore ends one (1) month before the expiration of the certification.

~~(e)~~ **(h)** The Indiana state department of health shall maintain a registry of QMAs who have current certification.

~~(f) A QMA who does not meet the six (6) hour per year in service requirement shall not be recertified. The QMA will be removed from the QMA registry and be required to reenter and satisfactorily complete a training program and pass the state approved competency evaluation test prior to again serving in the capacity of a QMA.~~ *(Indiana Health Facilities Council; 412 IAC 2-1-10; filed Jan 24, 2003, 8:26 a.m.: 26 IR 1938)*

SECTION 3. 412 IAC 2-1-14 IS AMENDED TO READ AS FOLLOWS:

412 IAC 2-1-14 Fees

Authority: IC 16-28-1-11

Affected: IC 16-28

Sec. 14. (a) An annual fee of ten dollars ($10), payable to the Indiana state department of health, is required for recertification of a QMA.

(b) The fee required by subsection (a) shall be due ~~thirty (30) days prior to~~ **on or before** the expiration of the QMA's certification.

(c) If the recertification fee and/or in-service education form required by section 10(c) of this rule is received after the expiration date of the certificate, a ten dollar ($10) late fee is assessed in addition to the recertification fee in subsection (a). *(Indiana Health Facilities Council; 412 IAC 2-1-14; filed Jan 24, 2003, 8:26 a.m.: 26 IR 1939)*

SECTION 4. 412 IAC 2-1-13 IS HEREBY REPEALED.